MASSACHUSETTS GENERAL HOSPITAL

HARVARD MEDICAL SCHOOL

Office of the President
55 Fruit Street
Boston, Massachusetts 02114-2696
Tel: 617-724-9300
Fax: 617-724-3377
E-mail: pslavin@mgh.harvard.edu

Peter L. Slavin, MD
President
Massachusetts General Hospital
Professor Health Care Policy
Harvard Medical School

Submitted Electronically via HPC-Testimony@state.ma.us

September 11, 2015

Dear Ms. Johnson:

Enclosed you will find written testimony for the Massachusetts General Hospital as requested for the upcoming cost trend hearings.

By my signature below, I certify that I am legally authorized and empowered to represent Massachusetts General Hospital for the purposes of this testimony, and acknowledge that it is signed under the pains and penalties of perjury.

Please direct any follow-up questions to Aimee Golbitz, Office of Government Affairs at Partners HealthCare (agolbitz@partners.org 617-278-1119).

Sincerely,

Peter L. Slavin, MD

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Monday, October 5, 2015, 9:00 AM
Tuesday, October 6, 2015, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on both days. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email at Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please complete your responses in the provided **Microsoft Word** template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

We encourage you to refer to and build upon your organization's 2013 or 2014 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. If a question is not applicable to your organization, please indicate so in your response.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth in CY2013 and CY2014 is 3.6%.
    a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.
    See MGH attachment 1

    b. What actions has your organization undertaken since January 1, 2014 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

    The MGH efforts towards meeting the 3.6% cost growth target is couched within a larger Partners Healthcare based effort. Partners is deploying a multi-faceted strategy to address health care cost trend that includes creation of a sustainable financing mechanism, new incentive structures, a high risk care management program, integrated mental health services, tools for specialist engagement, a post acute strategy, fostering patient engagement, and new technologies.

    At MGH we have initiatied a number of programs around specialist engagement, patient engagement, post acute care, high risk care management, and team based care which we discuss below. No singular effort will individually keep us below the target rate, but combined these efforts can scale to impact the total medical expense of patients cared for by MGH.

    c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?

    Partners is already a Pioneer ACO and has negotiated value based contracts with Blue Cross Blue Shield of MA, Tufts Health Plan, and Harvard Pilgrim Health Plan.

    At MGH we plan to continue the expansion of programs designed to better coordinate care within our organization, better collaborate with post acute care providers with whom we closely partner, and establish stronger connections to providers within Partners who do not work at an academic medical center.

    d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

While Partners is committed and will continue to make progress in reducing the growth in health care costs, it does so in the face of serious challenges. Removing these challenges would greatly speed the pace of progress towards lowering health care costs. These challenges include:

- **Ability to pursue new partnerships with community hospitals and community physicians**
- **Reimbursement models with non-aligned incentives (e.g., global budgets based on underlying fee for service payments; services such as nurse care managers not adequately reimbursed; incongrute incentives for post acute care providers with whom we work)**
- **Public payer shortfalls**
- **Duplicative reporting requirements**
- **Complex billing policies**
- **Lack of access to real-time patient claims data**
- **Labor costs**
- **Heightened demand for high-cost technology and interventions**
- **Pricing of new treatments by the pharmaceutical industry (ie – Sovaldi for Hepatitis C)**

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?

   Provider organizations are currently held accountable for the price of health care services set by other organizations; this risk reduces the appetite for expanding alternative payment methods. The price of specialty medications, surgical supplies, and imaging equipment are all set by other companies but under chapter 224 providers are held responsible for their contribution to total medical expense. We have created policies and protocols to ensure that these technologies are only used on appropriate patients but their contribution to overall cost growth is still large.

   Providers can either continue to be held accountable for these costs or the accountability can be removed. If it stays, similar pressures must be placed on other organizations to create new innovations with an eye towards value instead of revenue. Otherwise, provider organizations should not be held responsible for total medical expense growth due to pricing changes or high cost new innovations that do not replace existing technology.

3. In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.
   a. Please describe your organization's efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts.

MGH and Partners established a Skilled Nursing Facility (SNF) collaborative network to facilitate relationship building and quality improvement between the acute and post-acute settings. We have used this network to improve the frequency with which caregivers in the acute setting call their counterparts in the post-acute setting to provide them with a "warm handoff" of the patient. We have also initiated a reporting system to track safety concerns in this handoff process.

The hospital has established a Care Redesign workgroup specifically tasked with addressing readmissions. This team pulls together leaders from nursing, inpatient medical teams, the Emergency Department, Quality and Safety, and population health management teams to discuss and pilot new initiatives to measure and reduce readmissions.

MGH has been providing care management services for high risk Medicare patients since 2006. We have expanded this program into the commercial adult, pediatric, and Medicaid/MassHealth populations.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.
As part of the Readmissions Care Redesign work, we have worked with researchers at MIT to develop automated algorithms to predict readmission to the hospital based off of MGH data and prior research. These algorithms are being piloted in electronic systems to allow caregivers to identify patients with a high risk of readmission and initiate a series of steps intended to provide additional post-discharge support to compensate for that risk. We have also grown programs designed to provide patients with access to urgent care either at home or via one of the Partners Urgent Care centers. These efforts work to reduce avoidable ED utilization for both index admissions and readmissions.

Each population in our High Risk program requires unique algorithms to identify high risk patients and interventions to support them; we are in the process of fine tuning our approach in each of these new areas.

4. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Center for Health Information and Analysis in 2012, 2013, and 2015; and by the Health Policy Commission in 2014, prices paid to different Massachusetts providers for the same services vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value. Reports by the Office of the Attorney General have also identified significant variation in global budgets.
    a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?

See Partners response to #4.

b. Please describe your view of the impact of Massachusetts' price variation on the overall cost of care, as well as on the financial health and sustainability of community and lower-cost providers.

See Partners response to #4.

5. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
   a. Please describe ways that your organization has collaborated with other providers over the past 12 months 1) to integrate physical and behavioral health care services and provide care across a continuum to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.

In the last 12 months, there are a number of new initiatives that Partners and MGH has implemented to better indentify patients with behavioral health conditions and manage their care:

1. **Implementation of screening tools (beginning with depression) to better identify patients in PCP practices that need behavioral health care.**
2. **Implementation of D-Care (phone and electronic access to mental health consultation and resource finding to address psycho-social needs and specialty care, if needed)**
3. **Implementation of "Collaborative Care," an embedded Psychiatrist in PCP practices and behavioral health specialist support.**
4. **Telemedicine to increase the availability of mental health specialists.(3,246 telemedicine visits)**
5. **A hospital wide comprehensive approach to addressing patients' substance inuse disorders that has five components:**
   - **A specialized addiction consult team to better manage patients on the inpatient units who have comorbid medical and substance usde disorders**
   - **A transition clinic for those patients not yet connected to PCP or specialty care**
   - **Increased access to medication assisted treatments in the specialty clinics and in the PCP practices**
   - **Use of recovery coaches to better link patients from inpatient care to outpatient care at the hospital and in the community**
   - **Ongoing prevention, education and policy work with our community coalitions in Cheslea, Revere, and Charlestown.**

As discussed in last year's response, we also have the Integrated Care Management Program (iCMP) within all of its primary care practices. The program addresses

improved care coordination and management of individuals with medically chronic, complex and co-occurring behavioral health (BH) conditions. The program uses a team approach whereby BH/medical care managers, primary care, BH providers, other health professionals and patients collaborate in developing a coordinated treatment plan. This model of care necessitates enhanced and strengthened relationships with community-based programs including both hospitals and physicians. The collaboration between Partners and Neighborhood Health Plan (NHP) also allows for adaptation of iCMP to manage high cost/risk Medicaid patients. These interventions address the psycho-social determinants of healthcare.

b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.

All of these programs mentioned above have been rolled out to a limited number of PCP practices. Our goal is to increase the number of practices participating in the next 12 months. In addition, with the exception of the substance use disorder initiative, the program is primarily focused on depression. We are planning to incorporate an expanded list of conditions (depression, anxiety, and mood disorders) that will be incorporated in to some of these new initiatives.

With regard to the substance use disorder initiative:

- **Inpatient consultation – it has been piloted with 8 medical floors in the hospital. Our plan is to roll it out to additional floors this year**
- **Outpatient care – currently providing recovery coaches care in Revere, Chelsea, and Charlestown health centers. We are hoping to increase the number of recovery coaches and place them at the downtown PCP practices.**
- **A transition clinic for those patients who are not yet connected to care – expand the number the number of patients we can treat in the clinic.**

Our hope is that with all of these initiatives to reduce emergency room use and readmissions.

6. The Commission has identified the need for care delivery reforms that efficiently deliver coordinated, patient-centered, high-quality care, including in models such as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). What specific capabilities has your organization developed or does your organization plan to develop to successfully implement these models?

MGH and PHS have spent years transforming our primary care practices to PCMH, by the end of 2015 half of MGH primary care physicians will practice under such a model. As noted above, we also have multiple ACO contracts in place.

Many of the responses to prior questions mention specific capabilities to implement these models. We have a Performance Oversight Committee consisting of Medical Directors and Chief Financial Officers across Partners to guide our legal and financial implementation of this work. We have also created an internal incentive structure to provide organizations across Partners with financial incentives to implement these programs. Partners has established a Population Health Management team that facilitates the financing, regulatory, and measurement aspects of this work while the MGH has matched that investment with a local team to develop and implement new programs. Partners has also invested in an Electronic Data Warehouse (EDW) to combine financial, clinical, and claims data in one source to provide better insights into opportunities to reduce medical expense, accurate measurement of the cost of care we provide, and identify hot spots of cost growth.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please provide the following statistics related to consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b), including but not limited to a summary table (using the template below) showing for each quarter from January 2014 to the second quarter of 2015 the volume of inquiries by method of inquiry (e.g., in-person/phone, website), the number of consumer inquiries resolved (e.g., an estimate was provided), and the types of services (e.g., MRI of knee) to which consumer inquiries pertained. Please explain why any consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b) were unable to be resolved.

MGH		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
CY2014	Q1	IP: 10 OP: 51	N/A	61	IP: Natural Childbirth, Cesarean Section, Knee Replacement, Mastectomy, Breast Reconstruction, Sleep Study, Cardiac Ablation, Pectus Excavatum, Hepatectomy OP: Office visit/consult, MRI, CT Scan, Neuropsych Testing, Physical Therapy
	Q2	IP: 23 OP: 61	N/A	84	
	Q3	IP: 35 OP: 111	N/A	146	
	Q4	IP: 24 OP: 126	N/A	150	
CY2015	Q1	IP: 21 OP: 155	N/A	176	
	Q2	IP: 32 OP: 169	N/A	201	

2. Please submit a summary table showing for each year 2011 to 2014 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as **AGO Hospital Exhibit 1** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why.

   See attachment #2.

MGH Only
Does not include MD data
Data is Fiscal Year based
FY2010 - 2014 (Oct - Sept) is based on reconciled data, FY15 Q2 (Oct - Mar) is based on reconciled data

Fiscal Year	Cases	Net Patient Service Revenue	Total Costs	Facility
FY 2010	1,723,163	$ 1,963,524,655	$ 1,775,242,372	MGH
FY 2011	1,718,909	$ 2,073,647,332	$ 1,887,517,086	MGH
FY 2012	1,749,326	$ 2,235,229,789	$ 2,029,931,020	MGH
FY 2013	1,742,832	$ 2,297,737,071	$ 2,138,094,248	MGH
FY 2014	1,740,723	$ 2,345,271,649	$ 2,137,623,646	MGH
FY 2015 Q2	850,189	$ 1,202,280,758	$ 1,102,046,005	MGH

Financial Definitions

Net Patient Service Revenue = Contracted Payer Net Revenue - Free Care - Bad Debt - Denial - HSN Assessment + HSN Receipts
Total Costs = Direct + Indirect

Exhibit 1 AGO Questions to Providers

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. Please include POS payments under HMO.
3. Please include Indemnity payments under PPO.
4. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
5. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.
6. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
7. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
8. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.

9. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
10. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
11. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2011 - MGH	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/(Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$ 168.2		$ 14.6		$ 66.6	$ 2.8					$ 37.8	$ 342.5			
Tufts Health Plan	$ 46.8		$ 3.2		$ 1.7	$ 1.4					$ 27.1	$ 62.5			
Harvard Pilgrim Health Care	$ 57.5		$ 3.7		$ 1.8	$ 1.8					$ 44.3	$ 68.8			
Fallon Community Health Plan											$ 11.4				
CIGNA											$ 40.5	$ 0.7			
United Healthcare												$ 65.7			
Aetna											$ 60.7	$ 13.7			
Other Commercial												$ 152.4			
Total Commercial	$ 272.5		$ 21.4		$ 70.2	$ 5.9					$ 221.7	$ 706.4			
Network Health											$ 33.2				
Neighborhood Health Plan											$ 30.6				
BMC HealthNet, Inc.											$ 2.0				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											$ -				
Total Managed Medicaid											$ 65.8				
MassHealth											$ 78.9				
Tufts Medicare Preferred											$ 20.7				
Blue Cross Senior Options											$ 5.0				
Other Comm Medicare											$ 6.2	$ 11.9			
Commercial Medicare Subtotal											$ 32.0	$ 11.9			
Medicare												$ 485.1			
Other												$ 102.0			
GRAND TOTAL	$ 272.5		$ 21.4		$ 70.2	$ 5.9					$ 398.3	$ 1,305.3			

Notes:

[1] Revenue reported in $Millions.

[2] Data includes MGH.

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment.

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other smaller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate.

[5] Tufts Medicare Preferred includes some Claims-Based Revenue under Risk Contracts that is currently reported under FFS Arrangements; will update in future submission.

[6] Change from 2014 submission – Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employees/dependents for whom PHS is 100% at risk through self-insured employer account. Revenue for services provided to PHS employees/dependents currently available only for PHS providers in total; above $s estimated based on PHS in total revenue for services provided to PHS employees/dependents as a proportion of payer revenue.

[7] Revenue from Risk Contracts for Budget Surplus/(Deficit) and Quality Incentives currently available only for PHS providers in total; therefore, not included in hospital-specific submission.

2012 - MGH	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/(Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	$ 41.9		$ 3.8		$ 99.2	$ 85.6	n/a		n/a		$ 96.1	$ 362.2			
Tufts Health Plan	$ 11.6		$ 0.8		$ 22.7	$ 1.4	n/a		n/a		$ 33.2	$ 78.8			
Harvard Pilgrim Health Care	$ 14.3		$ 1.0		$ 24.6	$ 1.8	n/a		n/a		$ 73.2	$ 81.8			
Fallon Community Health Plan											$ 11.0				
CIGNA											$ 54.7	$ 1.0			
United Healthcare												$ 71.9			
Aetna											$ 68.1	$ 13.9			
Other Commercial												$ 151.9			
Total Commercial	$ 67.9		$ 5.6		$ 146.4	$ 88.8					$ 336.3	$ 761.5			
Network Health											$ 26.1				
Neighborhood Health Plan											$ 22.6				
BMC HealthNet, Inc.											$ 1.4				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid											$ 50.0				
MassHealth											$ 78.9				
Tufts Medicare Preferred											$ 22.1				
Blue Cross Senior Options											$ 7.2				
Other Comm Medicare											$ 3.4	$ 15.2			
Commercial Medicare Subtotal											$ 32.6	$ 15.2			
Medicare						$ 100.2		n/a				$ 442.2			
Other												$ 109.6			
GRAND TOTAL	$ 67.9		$ 5.6		$ 146.4	$ 189.0					$ 497.8	$ 1,328.5			

Notes:

[1] Revenue reported in $Millions.

[2] Data includes MGH.

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment.

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other smaller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate.

[5] Tufts Medicare Preferred includes some Claims-Based Revenue under Risk Contracts that is currently reported under FFS Arrangements; will update in future submission.

[6] Change from 2014 submission – Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employees/dependents for whom PHS is 100% at risk through self-insured employer

[7] Change from 2014 submission – Revenue under Risk Contracts and FFS Arrangements for Medicare has been restated with updated information.

[8] Revenue from Risk Contracts for Budget Surplus/(Deficit) and Quality Incentives currently available only for PHS providers in total; therefore, not included in hospital-specific submission.

2013 - MGH	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/(Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield					$ 106.8	$ 96.8	n/a		n/a		$ 92.0	$ 368.0			
Tufts Health Plan					$ 30.5	$ 1.4	n/a		n/a		$ 41.2	$ 84.2			
Harvard Pilgrim Health Care					$ 33.7	$ 1.9	n/a		n/a		$ 76.7	$ 89.4			
Fallon Community Health Plan											$ 11.8				
CIGNA											$ 55.2	$ 1.4			
United Healthcare												$ 71.6			
Aetna											$ 76.5	$ 16.3			
Other Commercial					$ 2.0							$ 153.7			
Total Commercial					$ 173.0						$ 353.5	$ 784.6			
Network Health											$ 33.0				
Neighborhood Health Plan					$ 2.4						$ 24.1				
BMC HealthNet, Inc.											$ 3.5				
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid															
Total Managed Medicaid					$ 2.4						$ 60.6				
MassHealth											$ 81.4				
Tufts Medicare Preferred											$ 24.4				
Blue Cross Senior Options											$ 6.8				
Other Comm Medicare											$ 5.7	$ 18.1			
Commercial Medicare Subtotal											$ 36.9	$ 18.1			
Medicare						$ 109.6		n/a				$ 450.8			
Other												$ 128.8			
GRAND TOTAL					$ 175.4	$ 109.6					$ 532.4	$ 1,382.2			

Notes:

[1] Revenue reported in $Millions.

[2] Data includes MGH.

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment.

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other smaller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate.

[5] Tufts Medicare Preferred includes some Claims-Based Revenue under Risk Contracts that is currently reported under FFS Arrangements; will update in future submission.

[6] Change from 2014 submission – Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employees/dependents for whom PHS is 100% at risk through self-insured employer account. Revenue for services provided to PHS employees/dependents currently available only for PHS providers in total; above $s estimated based on PHS in total revenue for services provided to PHS employees/dependents as a proportion of payer revenue.

[7] Change from 2014 submission – Revenue under Risk Contracts and FFS Arrangements for Medicare has been restated with updated information.

[8] Change from 2014 submission – Claims-Based Revenue under Risk Contracts includes revenue for services provided via risk agreement with Neighborhood Health Plan.

[9] Revenue from Risk Contracts for Budget Surplus/(Deficit) and Quality Incentives currently available only for PHS providers in total; therefore, not included in hospital-specific submission.

2014 - MGH	P4P Contracts				Risk Contracts						FFS Arrangements		Other Revenue		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/(Deficit) Revenue		Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield					$ 109.0	$ 101.4	n/a		n/a		$ 88.0	$ 374.3			
Tufts Health Plan					$ 35.3	$ 1.5	n/a		n/a		$ 32.1	$ 85.0			
Harvard Pilgrim Health Care					$ 24.5	$ 1.6	n/a		n/a		$ 79.6	$ 91.4			
Fallon Community Health Plan											$ 12.2				
CIGNA											$ 50.5	$ 7.4			
United Healthcare												$ 77.8			
Aetna											$ 70.6	$ 19.3			
Other Commercial					$ 9.1						$ 34.8	$ 122.1			
Total Commercial					$ 177.8	$ 104.5					$ 367.9	$ 777.3			
Network Health											$ 11.2				
Neighborhood Health Plan					$ 22.4		n/a	n/a			$ 29.7				
BMC HealthNet, Inc.															
Health New England															
Fallon Community Health Plan															
Other Managed Medicaid											$ 8.4				
Total Managed Medicaid					$ 22.4						$ 49.3				
MassHealth											$ 96.0				
Tufts Medicare Preferred											$ 23.8				
Blue Cross Senior Options											$ 7.1				
Other Comm Medicare												$ 30.3			
Commercial Medicare Subtotal											$ 30.9	$ 30.3			
Medicare						$ 113.6		n/a				$ 459.0			
Other												$ 116.2			
GRAND TOTAL					$ 200.2	$ 218.2					$ 544.1	$ 1,382.8			

Notes:

[1] Revenue reported in $Millions.

[2] Data includes MGH.

[3] Revenue based on payments minus denials, bad debt, free care surcharge, and uncompensated care assessment.

[4] Other Commercial primarily includes Coventry, UniCare GIC, NHP Commercial, PHCS, One Health, and other smaller payers; the HMO/PPO split of other commercial is an estimate due to data limitations, in total it is accurate.

[5] Tufts Medicare Preferred includes some Claims-Based Revenue under Risk Contracts that is currently reported under FFS Arrangements; will update in future submission.

[6] Claims-Based Revenue under Risk Contracts includes revenue associated with services provided to PHS employees/dependents for whom PHS is 100% at risk through self-insured employer account. Revenue for services provided to PHS employees/dependents currently available only for PHS providers in total; above $s estimated based on PHS in total revenue for services provided to PHS employees/dependents as a proportion of payer revenue.

[7] Revenue from Risk Contracts for Budget Surplus/(Deficit) and Quality Incentives currently available only for PHS providers in total; therefore, not included in hospital-specific submission.